

14367

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seabynville Del. Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seabynville, Del. Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Curry</u> Last <u>Curry</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>22</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 25, 1878</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mary Joanne Mumford</u> Address <u>Seabynville Del. Rural</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis & myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>approx 1 minute</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 19</u> to <u>Dec 22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>19</u> and that death occurred at <u>1:00</u> PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul B. McFadden M.D.</u>		ADDRESS (Street, city or town, state) <u>Seabynville, Del.</u> DATE SIGNED <u>24 Dec 59</u>	
PHYSICIAN'S NAME (Type) <u>Paul B. McFadden</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>12/28/59</u>	<u>Evergreen</u>	<u>Berlin Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Watson</u> ADDRESS <u>Pocomoke City, Md.</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
		DATE <u>DEC 30 '59</u>	<u>Arthur L. Howard</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 14368
 CERTIFICATE OF DEATH

Reg. Dist. No.

14334

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seabrook Del.</u>		c. LENGTH OF STAY IN 1b <u>10 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Seabrook Del.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Rhoda</u> First <u>J.</u> Middle <u>Curry</u> Last		4. DATE OF DEATH <u>Dec</u> Month <u>26</u> Day <u>19</u> Year <u>59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 25, 1894</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>private home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Timmons</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Gray</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>INFORMANT</u>	
17. ADDRESS <u>Seabrook Del.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gangrene left leg & sepsis</u> 450.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>obstruction of vessels of left leg</u> DUE TO (c) <u>severe ruptured anterior aneurysm</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u> <u>1 yr</u> <u>10-15 yrs</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>Jan</u> 19 <u>58</u> to <u>25 Dec</u> 19 <u>59</u> that I last saw the deceased alive on <u>23 Dec</u> 19 <u>59</u> and that death occurred at <u>3 A.</u> M. from the causes and on the date stated above.	
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>Herman A. Robbins</u> M.D. <u>Berlin, Md.</u>		PHYSICIAN'S NAME (Type) <u>Herman A. Robbins</u> <u>Berlin, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/31/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen</u>		22d. LOCATION (City, town, or county) (State) <u>Berlin Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u> ADDRESS <u>Pocomoke City, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 4 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

23621

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CERTIFICATE OF DEATH

Reg. Dist. No.

14335

14369

1. PLACE OF DEATH a. COUNTY <i>Mercutio</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill Road #1</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>md</i> b. COUNTY <i>Mercutio</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill Road #1</i>	
3. NAME OF DECEASED (Type or print) First <i>Annie</i> Middle <i>E.</i> Last <i>Davis</i>		4. DATE OF DEATH Month <i>Dec</i> Day <i>5</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 18 - 1873</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	11. BIRTHPLACE (State or foreign country) <i>Flaj Grange, md</i>
13. FATHER'S NAME <i>John P. Quist</i>		14. MOTHER'S MAIDEN NAME <i>Mary Mitchell</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>200.2</i> DUE TO <i>Cancer of Spleen</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Dec 1</i> , 1959, to <i>Dec 5</i> , 1959, that I last saw the deceased alive on <i>Dec 1</i> , 1959, and that death occurred at <i>4:30 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>C. G. Critcher</i>		DATE SIGNED <i>Dec 5 1959</i>	
PHYSICIAN'S NAME (Type) <i>Dr. C. G. Critcher</i>		ADDRESS (Street, city or town, state) <i>New Church</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>Dec 7/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>West Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Snow Hill md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Clayton Thomas</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	
ADDRESS <i>Snow Hill, md</i>		DATE <i>DEC 8 '59</i>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1935

BUREAU OF DEATH

1935

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14370

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stuart</u>		c. LENGTH OF STAY IN 1b <u>4 mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Maggie</u> Middle <u>H.</u> Last <u>Vickerson</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>2</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 11-1875</u>	9. AGE (In years last birthday) <u>84 1/2</u>	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Crittville, Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Daniel Holloway</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Laws</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs Laura Simon Salisbury, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X CARD IAC FAILURE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE 15 YRS</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CEREBRAL VASCULAR ACCIDENT 4 YRS AGO</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 WKS</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE</u> , 19 <u>50</u> , to <u>DEC. 2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>DEC 2</u> , 19 <u>57</u> , and that death occurred at <u>12:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>104 Bay Street, Snow Hill, Md.</u> DATE SIGNED <u>12-3-59</u>							
ACTUAL SIGNATURE <u>Robert C. LaMar</u>				M.D. <u>104 Bay Street, Snow Hill, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Robert C. LaMar, M. D.</u>				104 Bay Street, Snow Hill, Md.			
22a. BURIAL, CREMATION, or REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Dec 4/59</u>		<u>Old School Station</u>		<u>Snow Hill Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ray E. Summers</u>				ADDRESS <u>Snow Hill, Md</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 7 59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles E. Thomas</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

14337

14371

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin, Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Rural</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Iola</u> First <u>Virginia</u> Middle <u>Jassett</u> Last		4. DATE OF DEATH <u>Dec.</u> Month <u>21</u> Day <u>1959</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 18, 1911</u>
9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>maid</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>	11. BIRTHPLACE (State or foreign country) <u>Berlin, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Sid Purnell</u>		14. MOTHER'S MAIDEN NAME <u>Mae Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	
17. INFORMANT <u>Robert Jassett</u> Address <u>Berlin, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized metastases of Carcinoma</u> <u>156.1</u> DUE TO <u>Cancer of Liver</u> + <u>Anemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cancer of Liver</u> DUE TO (c) <u>Cancer of Liver</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u> <u>1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cancer of Brain + Spinal Cord - Bilateral Paralysis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 1947</u> , 19 <u>47</u> , to <u>Dec 21</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 21</u> , 19 <u>59</u> , and that death occurred at <u>5 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Berlin, Md.</u> DATE SIGNED <u>Armand Robles</u>			
ACTUAL SIGNATURE <u>Armand Robles</u> M.D.		PHYSICIAN'S NAME (Type) <u>Berlin, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-26-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen</u>	22d. LOCATION (City, town, or county) (State) <u>Berlin Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Watson</u> ADDRESS <u>Pocomoke City, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 29 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hand</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10378

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF CLERK		15. SIGNATURE OF JUDGE		16. SIGNATURE OF SHERIFF		17. SIGNATURE OF CORONER		18. SIGNATURE OF JURY		19. SIGNATURE OF WITNESSES		20. SIGNATURE OF DECEASED	
JAMES H. HARRIS		Male		45		White		1900		Baltimore, Md.		1945		Baltimore, Md.		10:30 AM		Heart Disease		Natural		J. H. Harris		D. M. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris			
21. I certify that I received the deceased's body for burial		22. I certify that I received the deceased's body for burial		23. I certify that I received the deceased's body for burial		24. I certify that I received the deceased's body for burial		25. I certify that I received the deceased's body for burial		26. I certify that I received the deceased's body for burial		27. I certify that I received the deceased's body for burial		28. I certify that I received the deceased's body for burial		29. I certify that I received the deceased's body for burial		30. I certify that I received the deceased's body for burial		31. I certify that I received the deceased's body for burial		32. I certify that I received the deceased's body for burial		33. I certify that I received the deceased's body for burial		34. I certify that I received the deceased's body for burial		35. I certify that I received the deceased's body for burial		36. I certify that I received the deceased's body for burial		37. I certify that I received the deceased's body for burial		38. I certify that I received the deceased's body for burial		39. I certify that I received the deceased's body for burial		40. I certify that I received the deceased's body for burial	

14372

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>WORCESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OCEANCITY M.D.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OCEANCITY</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>207 DORCHESTER ST.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>WARD</u> Middle <u>H.</u> Last <u>GRAY</u>				4. DATE OF DEATH Month <u>12</u> - Day <u>2</u> - Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 29, 1920</u> yrs. <u>70</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. WATERMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE GRAY</u>				14. MOTHER'S MAIDEN NAME <u>LIZZIE SAUAGE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-243851</u>		17. INFORMANT <u>Mrs. ELIZABETH GRAY</u> Address <u>OCEANCITY MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic Cardio vascular renal disease</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs.</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>1949</u> , to <u>2 Dec</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 2</u> , 19 <u>59</u> , and that death occurred at <u>7:40</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Nathaniel F. Thomas</u> M.D.				ADDRESS (Street, city or town, state) <u>Ocean City, Md</u> DATE SIGNED <u>12/3/59</u>			
PHYSICIAN'S NAME (Type) <u>Nathaniel F. Thomas</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/4/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ODD FELLOWS</u>		22d. LOCATION (City, town, or county) (State) <u>BISHOPVILLE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Watson & Gray Funeral</u> ADDRESS _____				24a. REC'D BY REGISTRAR <u>DEC 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

14339

CERTIFICATE OF DEATH

Reg. Dist. No.

14373

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>				c. LENGTH OF STAY IN 1b <u>88 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Snow Hill</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>E.</u> Last <u>Harris</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>30</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 24 - 1871</u>	
9. AGE (In years last birthday) <u>88 3/4</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>From home</u>		11. BIRTHPLACE (State or foreign country) <u>Snow Hill, md</u>	
12. CITIZEN OF WHAT COUNTRY? <u> </u>							
13. FATHER'S NAME <u>Burnell P. Pennwell</u>				14. MOTHER'S MAIDEN NAME <u>Hettie Jackson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>McEdward P. Harris</u>				Address <u>Snow Hill, md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion (Thrombosis)</u> <u>420.1</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> DUE TO <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatoid Arthritis</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>none</u> <u>10 yrs</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June</u> , 19 <u>50</u> , to <u>Dec 30</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 27</u> , 19 <u>59</u> , and that death occurred at <u>1:00 PM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Robert C. LaMar</u>				M.D. <u>104 Bay Street, Snow Hill, Maryland 12-31-59</u>			
PHYSICIAN'S NAME (Type) <u>Robert C. LaMar, M. D.</u>				<u>104 Bay Street, Snow Hill, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF <u>Jan 1/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Worcester County</u>	
22d. LOCATION (City, town or county) (State) <u>Snow Hill md</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne E. Harris</u>				ADDRESS <u>Snow Hill, md</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 4 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>							

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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14374

CERTIFICATE OF DEATH

14340

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Whaleyville</u>		c. LENGTH OF STAY IN 1b <u>60Yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>XX</u>		d. STREET ADDRESS <u>RFD</u>	
3. NAME OF DECEASED (Type or print) <u>JOHN</u> First <u>HEAN</u> Middle <u>HUDSON</u> Last		4. DATE OF DEATH <u>Dec. 10,</u> Month <u>1959</u> Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 20, 1870</u>
9. AGE (In years less birthday) yrs. <u>89</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Emma Hudson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>XX</u> (If yes, give year or dates of service) <u>XX</u>		16. SOCIAL SECURITY NO. <u>XX</u>	
17. INFORMANT <u>Mrs. Kate Hudson</u>		Address <u>Whaleyville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>intestinal obstruction</u> <u>570.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>probably volvulus</u> DUE TO (c) <u>hernia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2-3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Sensitivity</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec. 6, 1958</u> to <u>Dec. 10, 1959</u> , that I last saw the deceased alive on <u>Dec. 6, 1959</u> , and that death occurred at <u>2:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert A. Grubb</u> M.D.		DATE SIGNED <u>Dec. 12/10/59</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT A. GRUBB</u>		<u>BERLIN</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-12-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>XXXXX Dale</u>	22d. LOCATION (City, town, or county) (State) <u>Whaleyville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Peter Whaley Seligman, Del.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 15 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

14341

14375

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Accomack ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Stockton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Church 83x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Holland Rest Home		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LYDIA Middle E. Last JOHNSON		4. DATE OF DEATH Month December Day 18 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1882
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry S. Hurley		14. MOTHER'S MAIDEN NAME Julia A. Hall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs C. J. Ardis, Pocomoke City, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) 5 years		INTERVAL BETWEEN ONSET AND DEATH 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 15, 1959 , to Dec 18, 1959 , that I last saw the deceased alive on Dec 15, 1959 , and that death occurred at 11:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE C. E. Critcher M.D.		DATE SIGNED Dec 23 '59	
PHYSICIAN'S NAME (Type) C. E. Critcher, M. D.		New Church, Virginia	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-20-59	22c. NAME OF CEMETERY Nelson Cemetery	22d. LOCATION (City, town, or county) (State) Rural New Church, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Henry H. Watson		24a. REC'D BY REGISTRAR Pocomoke City, Md.	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE DEC 23 '59	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

14342

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wor</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL Ocean City</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Ocean City</u>	
c. LENGTH OF STAY IN 1b <u>8 years</u>		d. STREET ADDRESS <u>Marland Island</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 50</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>DAVID BRADFORD LYNCH</u>		4. DATE OF DEATH <u>Dec 25 19 59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 3, 1945</u>
9. AGE (In years last birthday) <u>14</u> yrs.		IF UNDER 1 YEAR Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min. <u>14</u>	IF UNDER 24 HRS. Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min. <u>14</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>C. EVERETT LYNCH</u>		14. MOTHER'S MAIDEN NAME <u>NANCY HARWOOD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>MR. WILLIAM LYNCH</u>		Address <u>Ocean City Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Burns 30 Total body surface</u> 816x DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>—</u> (c) <u>—</u> DUE TO (a) stating the underlying cause last. (b) <u>—</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>GAS TANK OF CAR exploded in collision</u>	
20c. TIME OF INJURY Month, Day, Year <u>Dec 25 19 59</u> Hour <u>7:30</u> a.m. <u>—</u> p.m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Auto</u>		20f. (City or town) <u>RURAL Ocean City</u> (County) <u>Wor</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Francis J. Townsend</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANCIS J. TOWNSEND</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/29/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) <u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Burbage</u>		ADDRESS <u>Berlin Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Burbage</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. RACE <i>White</i>	
5. PLACE OF BIRTH <i>New York City</i>		6. DATE OF BIRTH <i>Jan 15 1900</i>		7. PLACE OF DEATH <i>Home</i>		8. DATE OF DEATH <i>Jan 20 1945</i>	
9. OCCUPATION <i>Teacher</i>		10. CAUSE OF DEATH <i>Heart Disease</i>		11. MANNER OF DEATH <i>Natural</i>		12. SIGNATURE OF EXAMINER <i>[Signature]</i>	
13. SIGNATURE OF NEXT OF KIN <i>[Signature]</i>		14. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		15. SIGNATURE OF CORONER <i>[Signature]</i>		16. SIGNATURE OF JURY <i>[Signature]</i>	
17. SIGNATURE OF MEDICAL EXAMINER <i>[Signature]</i>		18. SIGNATURE OF COUNTY CLERK <i>[Signature]</i>		19. SIGNATURE OF CITY CLERK <i>[Signature]</i>		20. SIGNATURE OF STATE CLERK <i>[Signature]</i>	



TO BE FILLED BY THE MEDICAL EXAMINER. This certificate is to be filed with the County Clerk of the County in which the death occurred, and a copy is to be filed with the City Clerk of the City in which the death occurred. The original of this certificate is to be retained by the Medical Examiner.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND			2. USUAL RESIDENCE where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Worcester</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Berlin</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Berlin</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>R20 #2</u>	
3. NAME OF DECEASED (Type or print) <u>David</u> First <u>Lee</u> Middle <u>Purnell</u> Last			4. DATE OF DEATH Month <u>12</u> Day <u>28</u> Year <u>1959</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 9 - 52</u>		9. AGE (In years last birthday) yrs. <u>7</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School boy</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Educational</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
13. FATHER'S NAME <u>Wm. James Bratten</u>			14. MOTHER'S MAIDEN NAME <u>Ethel J. Purnell</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		17. INFORMANT <u>Ethel J. Purnell</u> Address <u>Berlin Md R20</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral hemorrhages</u> <u>910.0</u> DUE TO (b) <u>Fractured Skull</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>Head caught under an overturned piano</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was struck by an open door frame gateway</u> <u>overturning the old piano over on the deceased</u>			
20c. TIME OF INJURY Month, Day, Year How a.m. <u>12</u> p.m. <u>28</u> <u>59</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home of deceased</u>		20f. (City or town) (County) (State) <u>Rural Berlin Worcester Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>N.E. Sartorius Sr</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>12-29-59</u>	
EXAMINER'S NAME (Type) <u>N.E. Sartorius</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL-CREATION, REMOVAL (Specify)	22b. DATE THEREOF <u>12/30/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Dorsey</u>		22d. LOCATION (City, town, or county) (State) <u>Berlin (R20 #2) Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Burhage</u>		ADDRESS <u>Berlin Md</u>		24a. REC'D BY REGISTRAR <u>DATE JAN 4 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

DATE OF BIRTH
PLACE OF BIRTH

DATE OF DEATH
PLACE OF DEATH

DECEASED'S NAME

SEX
AGE

CAUSE OF DEATH

DIAGNOSIS

SYMPTOMS

DATE OF EXAMINATION

TIME OF EXAMINATION

PLACE OF EXAMINATION

DATE OF EXAMINATION

TIME OF EXAMINATION

PLACE OF EXAMINATION

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TIME OF EXAMINATION

PLACE OF EXAMINATION

DATE OF EXAMINATION

TIME OF EXAMINATION

PLACE OF EXAMINATION

STATE OF MASSACHUSETTS
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14345

Reg. Dist. No.

14364

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u> c. LENGTH OF STAY IN 1b <u>30 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Short St.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u> d. STREET ADDRESS <u>Short St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Eleanora</u> First <u>Sadler</u> Middle <u>Lou</u> Last 4. DATE OF DEATH Month <u>Dec</u> Day <u>23</u> Year <u>1959</u>				5. SEX <u>2</u> 6. COLOR OR RACE <u>C</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>July 18 1882</u> 9. AGE (In years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR Months <u>7</u> Days <u>11</u> IF UNDER 24 HRS. Hours <u>11</u> Min. <u>11</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lacemaking work</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u> 11. BIRTHPLACE (State or foreign country) <u>Md</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>James Manuel</u> 14. MOTHER'S MAIDEN NAME <u>Silvia Jenkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war and dates of service) 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Father Sadler</u> Address <u>Pocomoke City, Md</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Neuronoma</u> <u>492x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2 strokes during last month</u> DUE TO (c) <u>2 strokes during last month</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2 strokes during last month</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 or 4 days</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour <u>a. m.</u> p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>N. F. Sartorius Jr.</u> EXAMINER'S NAME (Type) <u>N. F. Sartorius Jr.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>1-2-60</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Stockton</u> 22d. LOCATION (City, town, or county) (State) <u>Stockton Md.</u>				24a. REC'D BY REGISTRAR <u>JAN 4 '60</u> DATE <u>JAN 4 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton</u> ADDRESS <u>-new church, Wg</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

CERTIFICATE OF DEATH

Reg. Dist. No. 14346

14365

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City				c. LENGTH OF STAY IN 1b 20 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) 710 Clarke Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First NANCY Middle CLARKE Last STERLING				4. DATE OF DEATH Month December Day 1 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 11, 1885	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME James P. Lawson				14. MOTHER'S MAIDEN NAME Melissa Sterling			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) ---		17. INFORMANT Address Mrs C. M. Taylor, Pocomoke City, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerotic Heart Disease DUE TO (c) Generalized Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Minutes years years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased on June 2, 1951 , to December 1, 1959 , that I last saw the deceased alive on November 23, 59 , and that death occurred at 730a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 302 Market St., Pocomoke City, Maryland. DATE SIGNED 12-2-59 ACTUAL SIGNATURE Charles W. Trader PHYSICIAN'S NAME (Type) Charles W. Trader							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12-3-59		22c. NAME OF CEMETERY First Baptist	
22d. LOCATION (City, town, or county) (State) Pocomoke City, Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE Henry J. Watson				ADDRESS Pocomoke City, Md.		24a. REC'D BY REGISTRAR DEC 4 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Harris							

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours of death. Page 4 of 4.

TO ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 of 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12345

<p>1. Name of deceased: James I. Brown</p>		<p>2. Sex: Male</p>	
<p>3. Date of birth: Nov. 11, 1882</p>		<p>4. Age: 41 years</p>	
<p>5. Place of birth: St. Louis, Mo.</p>		<p>6. Usual residence: 110 Centre Avenue, Baltimore City</p>	
<p>7. Cause of death: Heart disease</p>		<p>8. Date of death: Nov. 11, 1923</p>	
<p>9. Place of death: Baltimore City</p>		<p>10. Signature of physician: James I. Brown</p>	
<p>11. Signature of registrar: John D. M. Taylor</p>		<p>12. Signature of informant: James I. Brown</p>	
<p>13. Name of informant: James I. Brown</p>		<p>14. Address of informant: 110 Centre Avenue, Baltimore City</p>	
<p>15. Name of informant: James I. Brown</p>		<p>16. Address of informant: 110 Centre Avenue, Baltimore City</p>	
<p>17. Name of informant: James I. Brown</p>		<p>18. Address of informant: 110 Centre Avenue, Baltimore City</p>	
<p>19. Name of informant: James I. Brown</p>		<p>20. Address of informant: 110 Centre Avenue, Baltimore City</p>	
<p>21. Name of informant: James I. Brown</p>		<p>22. Address of informant: 110 Centre Avenue, Baltimore City</p>	
<p>23. Name of informant: James I. Brown</p>		<p>24. Address of informant: 110 Centre Avenue, Baltimore City</p>	
<p>25. Name of informant: James I. Brown</p>		<p>26. Address of informant: 110 Centre Avenue, Baltimore City</p>	
<p>27. Name of informant: James I. Brown</p>		<p>28. Address of informant: 110 Centre Avenue, Baltimore City</p>	
<p>29. Name of informant: James I. Brown</p>		<p>30. Address of informant: 110 Centre Avenue, Baltimore City</p>	
<p>31. Name of informant: James I. Brown</p>		<p>32. Address of informant: 110 Centre Avenue, Baltimore City</p>	
<p>33. Name of informant: James I. Brown</p>		<p>34. Address of informant: 110 Centre Avenue, Baltimore City</p>	
<p>35. Name of informant: James I. Brown</p>		<p>36. Address of informant: 110 Centre Avenue, Baltimore City</p>	
<p>37. Name of informant: James I. Brown</p>		<p>38. Address of informant: 110 Centre Avenue, Baltimore City</p>	
<p>39. Name of informant: James I. Brown</p>		<p>40. Address of informant: 110 Centre Avenue, Baltimore City</p>	
<p>41. Name of informant: James I. Brown</p>		<p>42. Address of informant: 110 Centre Avenue, Baltimore City</p>	
<p>43. Name of informant: James I. Brown</p>		<p>44. Address of informant: 110 Centre Avenue, Baltimore City</p>	
<p>45. Name of informant: James I. Brown</p>		<p>46. Address of informant: 110 Centre Avenue, Baltimore City</p>	
<p>47. Name of informant: James I. Brown</p>		<p>48. Address of informant: 110 Centre Avenue, Baltimore City</p>	
<p>49. Name of informant: James I. Brown</p>		<p>50. Address of informant: 110 Centre Avenue, Baltimore City</p>	
<p>51. Name of informant: James I. Brown</p>		<p>52. Address of informant: 110 Centre Avenue, Baltimore City</p>	
<p>53. Name of informant: James I. Brown</p>		<p>54. Address of informant: 110 Centre Avenue, Baltimore City</p>	
<p>55. Name of informant: James I. Brown</p>		<p>56. Address of informant: 110 Centre Avenue, Baltimore City</p>	
<p>57. Name of informant: James I. Brown</p>		<p>58. Address of informant: 110 Centre Avenue, Baltimore City</p>	
<p>59. Name of informant: James I. Brown</p>		<p>60. Address of informant: 110 Centre Avenue, Baltimore City</p>	
<p>61. Name of informant: James I. Brown</p>		<p>62. Address of informant: 110 Centre Avenue, Baltimore City</p>	
<p>63. Name of informant: James I. Brown</p>		<p>64. Address of informant: 110 Centre Avenue, Baltimore City</p>	
<p>65. Name of informant: James I. Brown</p>		<p>66. Address of informant: 110 Centre Avenue, Baltimore City</p>	
<p>67. Name of informant: James I. Brown</p>		<p>68. Address of informant: 110 Centre Avenue, Baltimore City</p>	
<p>69. Name of informant: James I. Brown</p>		<p>70. Address of informant: 110 Centre Avenue, Baltimore City</p>	
<p>71. Name of informant: James I. Brown</p>		<p>72. Address of informant: 110 Centre Avenue, Baltimore City</p>	
<p>73. Name of informant: James I. Brown</p>		<p>74. Address of informant: 110 Centre Avenue, Baltimore City</p>	
<p>75. Name of informant: James I. Brown</p>		<p>76. Address of informant: 110 Centre Avenue, Baltimore City</p>	
<p>77. Name of informant: James I. Brown</p>		<p>78. Address of informant: 110 Centre Avenue, Baltimore City</p>	
<p>79. Name of informant: James I. Brown</p>		<p>80. Address of informant: 110 Centre Avenue, Baltimore City</p>	
<p>81. Name of informant: James I. Brown</p>		<p>82. Address of informant: 110 Centre Avenue, Baltimore City</p>	
<p>83. Name of informant: James I. Brown</p>		<p>84. Address of informant: 110 Centre Avenue, Baltimore City</p>	
<p>85. Name of informant: James I. Brown</p>		<p>86. Address of informant: 110 Centre Avenue, Baltimore City</p>	
<p>87. Name of informant: James I. Brown</p>		<p>88. Address of informant: 110 Centre Avenue, Baltimore City</p>	
<p>89. Name of informant: James I. Brown</p>		<p>90. Address of informant: 110 Centre Avenue, Baltimore City</p>	
<p>91. Name of informant: James I. Brown</p>		<p>92. Address of informant: 110 Centre Avenue, Baltimore City</p>	
<p>93. Name of informant: James I. Brown</p>		<p>94. Address of informant: 110 Centre Avenue, Baltimore City</p>	
<p>95. Name of informant: James I. Brown</p>		<p>96. Address of informant: 110 Centre Avenue, Baltimore City</p>	
<p>97. Name of informant: James I. Brown</p>		<p>98. Address of informant: 110 Centre Avenue, Baltimore City</p>	
<p>99. Name of informant: James I. Brown</p>		<p>100. Address of informant: 110 Centre Avenue, Baltimore City</p>	

14366

CERTIFICATE OF DEATH

Reg. Dist. No.

14347

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) 703 Second Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 42, Pocomoke City	
d. NAME OF HOSPITAL (If not in hospital, give street address) 703 Second Street		d. STREET ADDRESS 703 Second Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle HENRY Last WATSON		4. DATE OF DEATH Month December Day 23 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 11, 1903
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Seafood	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles R. Watson		14. MOTHER'S MAIDEN NAME Nancy Carey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Mrs Cassie R. Watson		Address 703 Second Street Pocomoke City, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO (b) Coronary Artery Disease DUE TO (c) Generalized Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH few minutes 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 5, 1956 to Dec 23, 1959 , that I last saw the deceased alive on Dec 23, 1959 , and that death occurred at 11:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles W. Trader M.D.		ADDRESS (Street, city or town, state) 302 Market St Pocomoke City, Md.	
PHYSICIAN'S NAME (Type) Charles W. Trader, M.D.		DATE SIGNED 12-27-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-27-59	
22c. NAME OF CEMETERY Salem Methodist		22d. LOCATION (City, town, or county) (State) Pocomoke City, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Henry H. Watson		ADDRESS Pocomoke City, Md.	
24a. REC'D BY REGISTRAR DEC 30 59		24b. REGISTRAR'S SIGNATURE Arthur S. Thayer	

MEDICAL CERTIFICATION

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

